IDAHO DEPARTMENT OF
HEALTH & WELFARE

SERVICE AGREEMENT

Client Information:

Client Name		Home Phone	
Address		Medicaid #	XXXXXX
City		Date Of Birth	
State		Marital Status	
Zip		Assessment Date	
Language		Admission Date	XX/XX/XXXX
Gender		Next Review Date	
Housing Arrangement		Facility Name	
Region		Facility Phone	
Assessment Type			

Primary Physician:

Physician Name		Phone	

Goals	Outcomes

Participant Strengths:	Participant Preferences:

General information
Health monitoring (blood level checks, oxygen, etc.), special diets etc. Medical appointments including dental, vision, general medical and medical specialty appointments. Identify medical transportation. **CFH Only:** Document requests for Time Alone in this section.

Client Name		Medicaid #	

Preparing Meals

Assistance Required:	Identify the participant's ability to prepare own food. Consider safety issues such as whether burners are left on.	Available Support:	Unmet Needs:

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
Responsible Party: _____

Written Care Plan (Comments):

Eating Meals

Assistance Required:	Identify the level of assistance needed to perform the activity of feeding and eating with special equipment if regularly used or special tray setup.	Available Support:	Unmet Needs:

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
Responsible Party: _____

Written Care Plan (Comments):

Toileting

Assistance Required:	Identify the participant's ability to get to and from the toilet (including commode, bedpan, and urinal), manage colostomy or other devices, to cleanse after eliminating, and to adjust clothing.	Available Support:	Unmet Needs:

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
Responsible Party: _____

Written Care Plan (Comments):

Mobility

Assistance Required:	Identify the participant's physical ability to get around, both inside and outside, using mechanical aids if needed.	Available Support:	Unmet Needs:

Client Name		Medicaid #	

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
Responsible Party: _____

Written Care Plan (Comments):

Transferring

Assistance Required:	Identify the participant's ability to transfer when in bed or wheelchair.	Available Support:	Unmet Needs:

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
Responsible Party: _____

Written Care Plan (Comments):

Personal Hygiene

Assistance Required:	Identify the participant's ability to shave, care for mouth, and comb hair.	Available Support:	Unmet Needs:

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
Responsible Party: _____

Written Care Plan (Comments):

Dressing

Assistance Required:	Identify the participant's ability to dress and undress, including selection of clean clothing or appropriate seasonal clothing.	Available Support:	Unmet Needs:

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
Responsible Party: _____

Written Care Plan (Comments):

Bathing

Client Name		Medicaid #	

Assistance Required:	Identify the participant's ability to bathe and wash hair.	Available Support:	Unmet Needs:

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
Responsible Party: _____

Written Care Plan (Comments):

Access to Transportation

Assistance Required:	Identify the participant's ability to get to and from stores, medical facilities, and other community activities, considering the ability both to access and use transportation.	Available Support:	Unmet Needs:

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
Responsible Party: _____

Written Care Plan (Comments):

Shopping

Assistance Required:	Identify the participant's ability to shop for food and personal items.	Available Support:	Unmet Needs:

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
Responsible Party: _____

Written Care Plan (Comments):

Laundry

Assistance Required:	Identify the participant's ability to do own laundry either at home or at laundromat.	Available Support:	Unmet Needs:

Client Name		Medicaid #	

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
Responsible Party: _____

Written Care Plan (Comments):

Housework

Assistance Required:	Identify the participant's ability to clean surfaces and furnishings in his/her living quarters, including dishes, floors and bathroom fixtures and disposing of household garbage.	Available Support:	Unmet Needs:

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
Responsible Party: _____

Written Care Plan (Comments):

Night Needs

Assistance Required:	Identify the participant's need for assistance during the night.	Available Support:	Unmet Needs:

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
Responsible Party: _____

Written Care Plan (Comments):

Emergency Response

Assistance Required:	Identify the participant's ability to recognize the need for and to seek emergency help.	Available Support:	Unmet Needs:

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
Responsible Party: _____

Written Care Plan (Comments):

Medication

Client Name		Medicaid #	

Assistance Required:	Identify the participant's ability/willingness to administer his/her own medication.	Available Support:	Unmet Needs:

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
Responsible Party: _____

Written Care Plan (Comments):

Supervision

Assistance Required:	Identify the participant's ability to manage his/her life, including needs and activities.	Available Support:	Unmet Needs:

Provider Care Plan Frequency: ___Daily ___Weekly ___Monthly ___As Needed
Responsible Party: _____

Written Care Plan (Comments):

Community Supports and Other Services

Special Equipment

Equipment to meet the special needs for physical/emotional disability or impairment. Including; wheelchairs, walkers, canes, hearing aids, orthopedic supports, glasses, contacts, etc.

Community Supports / Behavior Management

Use of community services such as day treatment, workshop programs, financial or legal services, vocational training, case management, targeted service coordination, transportation, etc. Please include family support, physicians, attorneys, social workers, etc.
Is there a Behavior Management Plan? *If YES please attach to the Service Plan*

Client Name		Medicaid #	

Health & Safety Risks

Intervention

Identify health & safety risks such as falling, memory/cognitive impairment, behavioral issues that present a risk to the participant or others, etc.	Identify intervention needed to address each health or safety risk during service delivery

Backup Plan

I will accept a substitute caregiver if my caregiver is not available	
I will use informal supports if my caregiver is not available	
Name:	Phone:
Name:	Phone:
Name:	Phone:
Communication Plan (include detailed instructions for contacting caregiver(s) and/or informal supports and include the participant's urgent needs and any actions that are required to ensure service delivery):	

The signers have read and agree to the provisions of this document. Each has retained a copy for their records. If there is any disagreement, such should be noted. Attach any signed and dated physician's orders, admission records and documentation concerning special needs.

Participant

My signature indicates that I participated in the development of my service plan, and that I agree to the delivery of services as outlined in my plan.

_____ _____

Participant Date

_____ _____

Legal Guardian Date

Service Provider

My signature indicates service will be delivered according to the service plan and consistent with home and community based requirements.

_____ _____

Service Provider Name Date